

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011799</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/14/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN TREE AT POST ROAD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8800 SPOON DRIVE</b> <b>INDIANAPOLIS, IN 46219</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00089477 and IN00090252.</p> <p>Complaint IN00089477 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00090252 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 13, 14, 2011</p> <p>Facility number: 011799 Provider number: 011799 AIM number: N/A</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Census payor type: Other: 30 Total: 30</p> <p>Sample: 4</p> <p>Green Tree at Post Road was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaints IN00089477 and IN00090252.</p> <p>Quality review 6/16/11 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1